

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

FILED NOV 30 1962

1003

11216

-62-044993

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b over 9 yrs Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY c. CITY OR TOWN St. Louis d. STREET ADDRESS 1462a Shawmut (If outside, give location) Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MINNIE UDIN			4. DATE OF DEATH Month Day Year Nov. 21, 1962		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/4/1900		9. AGE (last birthday) 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Russia		12. CITIZEN OF WHAT COUNTRY AUSTRIA	
13a. FATHER'S NAME Abraham Chasnov		13b. MOTHER'S MAIDEN NAME Rose (unk)		14. NAME OF HUSBAND OR WIFE Louis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Address Alberts Udin 1925 001 Ave St. Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> DUE TO (b) <u>Metastatic Hypernephroma</u> DUE TO (c) <u>180x</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE			
21. I attended the deceased from <u>Aug. 21, 1953</u> to <u>Nov. 21, 1962</u> and last saw her <u>alive on Nov. 21, 1962</u> Death occurred <u>8:20 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. <u>C.A. Valtierra, M.D.</u>					
22a. SIGNATURE (Print name or title) C.A. Valtierra, M.D.			22b. ADDRESS 5400 Arsenal St.		22c. DATE SIGNED 11-22-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.		23b. DATE 11/25/62		23c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagadol	
23d. LOCATION (City, town, or county) Ladue Mo.		23e. STATE (State)			
24. FUNERAL DIRECTOR Berger Memorial 4715 McPerson			25. DATE RECD. BY LOCAL REG. NOV 23 1962		
26. REGISTRAR'S SIGNATURE Road Smith, M.D.					

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed *Edward J. Davis*

Licensed Embalmer No. 3988

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.